

		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045203

Facility Name: GROSSE POINTE MANOR

Address: 6601 WEST TOUHY AVENUE NILES 60714
Number City Zip Code

County: COOK

Telephone Number: (847)-647-9875 Fax # (847)-588-0870

IDPA ID Number: 36-4411703001

Date of Initial License for Current Owners: 09/07/01

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____
(Type or Print Name) SHERRY MAUER
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GROSSE POINTE MANOR

0045203 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,710</u>	<u>1,710</u>	8
9	SNF/PED					9
10	ICF	<u>16,086</u>	<u>7,277</u>	<u>133</u>	<u>23,496</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,086</u>	<u>7,277</u>	<u>1,843</u>	<u>25,206</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 69.76%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started

01/01/01

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date

01/01/01

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

47

and days of care provided

1,710

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year:

12/31/2002

Fiscal Year:

12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	208,542	20,078	4,160	232,780		232,780		232,780			1
2	Food Purchase		156,855		156,855	(16,699)	140,156	(2,625)	137,531			2
3	Housekeeping	70,634	18,367		89,001		89,001		89,001			3
4	Laundry	43,526	11,649	1,531	56,706		56,706		56,706			4
5	Heat and Other Utilities			96,107	96,107		96,107	552	96,659			5
6	Maintenance	55,080	34,451	16,665	106,196		106,196	1,691	107,887			6
7	Other (specify):*			9,248	9,248		9,248	44	9,292			7
8	TOTAL General Services	377,782	241,400	127,711	746,893	(16,699)	730,194	(338)	729,856			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,224,438	58,882	19,453	1,302,773		1,302,773	(36)	1,302,737			10
10a	Therapy			2,816	2,816		2,816		2,816			10a
11	Activities	89,019	4,594	1,774	95,387		95,387		95,387			11
12	Social Services	35,227		1,418	36,645		36,645		36,645			12
13	Nurse Aide Training			1,950	1,950		1,950		1,950			13
14	Program Transportation			1,053	1,053		1,053		1,053			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,348,684	63,476	34,464	1,446,624		1,446,624	(36)	1,446,588			16
	C. General Administration											
17	Administrative	87,683			87,683		87,683	36,450	124,133			17
18	Directors Fees											18
19	Professional Services			60,086	60,086		60,086	261	60,347			19
20	Dues, Fees, Subscriptions & Promotions			30,870	30,870		30,870	(26,013)	4,857			20
21	Clerical & General Office Expenses	87,516	16,417	60,289	164,222		164,222	(50,679)	113,543			21
22	Employee Benefits & Payroll Taxes			307,343	307,343	16,699	324,042		324,042			22
23	Inservice Training & Education			1,375	1,375		1,375		1,375			23
24	Travel and Seminar							147	147			24
25	Other Admin. Staff Transportation			284	284		284		284			25
26	Insurance-Prop.Liab.Malpractice			71,498	71,498		71,498	1,816	73,314			26
27	Other (specify):*			6,132	6,132		6,132	1,375	7,507			27
28	TOTAL General Administration	175,199	16,417	537,877	729,493	16,699	746,192	(36,643)	709,549			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,901,665	321,293	700,052	2,923,010		2,923,010	(37,017)	2,885,993			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			8,952	8,952		8,952	169,130	178,082			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,003	65,003		65,003	373,115	438,118			32
33	Real Estate Taxes			105,000	105,000		105,000	1,604	106,604			33
34	Rent-Facility & Grounds			486,000	486,000		486,000	(486,000)				34
35	Rent-Equipment & Vehicles			10,069	10,069		10,069	4,693	14,762			35
36	Other (specify):* VAC/SICK PAID			(11,380)	(11,380)		(11,380)		(11,380)			36
37	TOTAL Ownership			663,644	663,644		663,644	62,542	726,186			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		66,688	55,297	121,985		121,985	(647)	121,338			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		66,688	109,500	176,188		176,188	(647)	175,541			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,901,665	387,981	1,473,196	3,762,842		3,762,842	24,878	3,787,720			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(85,803)	30		9
10	Interest and Other Investment Income	(55)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,134)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,491)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(5,677)	21		18
19	Entertainment		20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(860)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,132)	27		24
25	Fund Raising, Advertising and Promotional	(26,338)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(40,400)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (167,940)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	192,818		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 192,818		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 24,878		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	MARKETING SALARIES	\$ (40,400)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(40,400)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,625)	0	0	0	0	0	0	0	0	0	0	(2,625)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	552	0	0	0	0	0	0	0	0	552	5
6	Maintenance	0	0	1,691	0	0	0	0	0	0	0	0	1,691	6
7	Other (specify):*	0	0	44	0	0	0	0	0	0	0	0	44	7
8	TOTAL General Services	(2,625)	0	2,287	0	0	0	0	0	0	0	0	(338)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(36)	0	0	0	0	0	(36)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	(36)	0	0	0	0	0	(36)	16
	C. General Administration													
17	Administrative	0	0	0	36,450	0	0	0	0	0	0	0	36,450	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(860)	0	1,121	0	0	0	0	0	0	0	0	261	19
20	Fees, Subscriptions & Promotions	(26,388)	0	375	0	0	0	0	0	0	0	0	(26,013)	20
21	Clerical & General Office Expenses	(46,077)	(30,000)	21,990	3,408	0	0	0	0	0	0	0	(50,679)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	147	0	0	0	0	0	0	0	0	147	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,816	0	0	0	0	0	0	0	0	1,816	26
27	Other (specify):*	(6,132)	0	3,780	0	3,727	0	0	0	0	0	0	1,375	27
28	TOTAL General Administration	(79,457)	(30,000)	29,229	39,858	3,727	0	0	0	0	0	0	(36,643)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(82,082)	(30,000)	31,516	39,858	3,727	(36)	0	0	0	0	0	(37,017)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(85,803)	252,444	2,489	0	0	0	0	0	0	0	0	169,130 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(55)	370,980	2,190	0	0	0	0	0	0	0	0	373,115 32
33	Real Estate Taxes	0	0	1,604	0	0	0	0	0	0	0	0	1,604 33
34	Rent-Facility & Grounds	0	(486,000)	0	0	0	0	0	0	0	0	0	(486,000) 34
35	Rent-Equipment & Vehicles	0	0	4,693	0	0	0	0	0	0	0	0	4,693 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(85,858)	137,424	10,976	0	0	0	0	0	0	0	0	62,542 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	(647)	0	0	0	0	0	(647) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	(647)	0	0	0	0	0	(647) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(167,940)	107,424	42,492	39,858	3,727	(683)	0	0	0	0	0	24,878 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	21	BOOKKEEPING FEES	\$ 30,000	DYNAMIC HEALTHCARE CONSULTANTS		\$	\$ (30,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	486,000	GROSS POINTE MANOR REALTY LLC			(486,000)	7
8	V	30	DEPRECIATION		" "		252,444	252,444	8
9	V	32	INTEREST		" "		370,980	370,980	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 516,000			\$ 623,424	\$ * 107,424	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization			6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization			Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	DYNAMIC HEALTHCARE CONSULTANTS			100.00%	\$ 552	\$ 552	15
16	V	6	REPAIRS & MAINT.		"			100.00%	1,691	1,691	16
17	V	7	EMP. BEN. - GEN. SERVICES		"			100.00%	44	44	17
18	V	19	PROFESSIONAL FEE		"			100.00%	1,121	1,121	18
19	V	20	DUES AND SUBSCRIPTION		"			100.00%	375	375	19
20	V	21	CLERICAL & GENERAL		"			100.00%	21,990	21,990	20
21	V	24	SEMINAR AND TRAVEL		"			100.00%	147	147	21
22	V	26	INSURANCE		"			100.00%	1,816	1,816	22
23	V	27	EMP. BEN. - GEN. ADMIN		"			100.00%	3,780	3,780	23
24	V	30	DEPRECIATION		"			100.00%	2,489	2,489	24
25	V	32	INTEREST		"			100.00%	2,190	2,190	25
26	V	33	REAL ESTATE TAXES		"			100.00%	1,604	1,604	26
27	V	35	EQUIPMENT RENTAL		"			100.00%	4,693	4,693	27
28	V										28
29	V										29
30	V										30
31	V										31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total			\$					\$ 42,492	\$ * 42,492	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$	\$	15
16	V	10	NURSING CMP. - SUE G.		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			16
17	V	17	ADMIN. CMP. - M. MAUER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	21,151	21,151	17
18	V	17	ADMIN. CMP. - M. AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			18
19	V	17	ADMIN. CMP. - F. AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			20
21	V	17	ADMIN. CMP. - S. KOPLIN		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			21
22	V	17	ADMIN. CMP. - D. MAGAFAS		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	7,092	7,092	22
23	V	17	ADMIN. CMP. - E. CASSON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			24
25	V	17	ADMIN. CMP. - S. LEVY		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	8,207	8,207	25
26	V	17	ADMIN. CMP. - HOWARD ALTER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		DYNAMIC HEALTHCARE CONSULTANTS	100.00%			27
28	V	21	CLERICAL. CMP. - S. AARON		DYNAMIC HEALTHCARE CONSULTANTS	100.00%	3,408	3,408	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 39,858	\$ * 39,858	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	\$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	\$		15
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%			16
17	V	27	EMP. BEN. - M. MAUER		" " "	100.00%	919	919	17
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%			18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%			19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%			21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	983	983	22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	1,185	1,185	25
26	V	27	EMP. BEN. - HOWARD ALTER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%			27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	640	640	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 3,727	\$ * 3,727	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	\$ 251	LINCOLN MEDICAL SUPPLIES, INC.		\$ 215	\$ (36)	15
16	V	39	ANCILLARY EXPENSE	4,490	" " "		3,843	(647)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 4,741			\$ 4,058	\$ * (683)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHERRY MAUER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	\$ 87,683	17-1	1
2	SHERRY MAUER		NURSING					SALARY	14,000	10-1	2
3	MARSHALL MAUER		ADMINISTRATIVE					SALARY	21,151	17-7	3
4	SHARON AARON		CLERICAL	0.00				SALARY	3,408	21-7	4
5	DOVIE MAUER		FILE CLERK	0.00				SALARY	1,775	21-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 128,017		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GROSSE POINTE MANOR# 0045203 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
Street Address 3359 W. MAIN ST.
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 679-8219
Fax Number (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	441,841	13	\$ 9,671	\$	25,206	\$ 552	1
2	6	REPAIRS & MAINT.	" "	441,841	13	29,636	3,380	25,206	1,691	2
3	7	EMP. BEN. - GEN. SERVICES	" "	441,841	13	778		25,206	44	3
4	19	PROFESSIONAL FEE	" "	441,841	13	19,651		25,206	1,121	4
5	20	DUES AND SUBSCRIPTION	" "	441,841	13	6,566		25,206	375	5
6	21	CLERICAL & GENERAL	" "	441,841	13	385,463	300,175	25,206	21,990	6
7	24	SEMINAR AND TRAVEL	" "	441,841	13	2,576		25,206	147	7
8	26	INSURANCE	" "	441,841	13	31,835		25,206	1,816	8
9	27	EMP. BEN. - GEN. ADMIN	" "	441,841	13	66,254		25,206	3,780	9
10	30	DEPRECIATION	" "	441,841	13	43,634		25,206	2,489	10
11	32	INTEREST	" "	441,841	13	38,384		25,206	2,190	11
12	33	REAL ESTATE TAXES	" "	441,841	13	28,121		25,206	1,604	12
13	35	EQUIPMENT RENTAL	" "	441,841	13	82,269		25,206	4,693	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 744,838	\$ 303,555		\$ 42,492	25

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
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City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 679-8219
Fax Number (847) 679-7377

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOUR	40	10	\$ 59,032	\$ 59,032			1
2	10	NURSING CMP. - SUE G.	" "	40	1	32,744	32,744			2
3	17	ADMIN. CMP. - M. MAUER	" "	40	12	363,103	363,103	2	21,151	3
4	17	ADMIN. CMP. - M. AARON	" "	40	10	487,988	487,988			4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	193,312	193,312			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	37	2	153,497	153,497			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	8	71,542	71,542			7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	9	87,437	87,437	4	7,092	8
9	17	ADMIN. CMP. - E. CASSON	" "	38	1	31,246	31,246			9
10	17	ADMIN. CMP. - S. BOGEN	" "	45	2	54,060	54,060			10
11	17	ADMIN. CMP. - S. LEVY	" "	45	12	140,632	140,632	3	8,207	11
12	17	ADMIN. CMP. - HOWARD ALTER	" "	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	12	157,563	157,563			13
14	21	CLERICAL CMP. - S. AARON	" "	40	12	58,502	58,502	2	3,408	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,902,658	\$ 1,902,658		\$ 39,858	25

Facility Name & ID Number GROSSE POINTE MANOR# 0045203

Report Period Beginning:

01/01/2002Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
Street Address 3359 W. MAIN ST.
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 679-8219
Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	10	\$ 5,020	\$		\$	1
2	15	EMP BEN - SUE G.	" "	40	1	3,128				2
3	27	EMP BEN - M. MAUER	" "	40	12	15,782		2	919	3
4	27	EMP BEN - M. AARON	" "	40	10	18,288				4
5	27	EMP BEN - F. AARON	" "	45	6	28,556				5
6	27	EMP BEN - S GOLDSTEIN	" "	37	2	25,672				6
7	27	EMP BEN - S. KOPLIN	" "	40	8	22,644				7
8	27	EMP BEN - D. MAGAFAS	" "	45	9	12,125		4	983	8
9	27	EMP BEN - E. CASSON	" "	38	1	3,418				9
10	27	EMP BEN - S. BOGEN	" "	45	2	5,010				10
11	27	EMP BEN - S. LEVY	" "	45	12	20,299		3	1,185	11
12	27	EMP BEN - H. ALTER	" "	40	1	1,296				12
13	27	EMP BEN - NON-OWNER	" "	45	12	23,491				13
14	27	EMP BEN - S. AARON	" "	40	12	10,982		2	640	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 195,711	\$		\$ 3,727	25

Facility Name & ID Number GROSSE POINTE MANOR # 0045203 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DYNAMIC HEALTHCARE CONSULTANTS
Street Address 3359 W. MAIN ST.
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 679-8219
Fax Number (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	LINCOLN MEDICAL SUPPLIES				\$	\$			1
	2	10 MEDICAL SUPPLIES	DIRECT ALLOCATION						215	2
	3	39 ANCILLARY EXPENSE	" "						3,843	3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		4,058	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1	MB FINANCIAL BANK		X	MORTGAGE			\$	4,916,688			\$	370,980	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	MB FINANCIAL BANK		X	LINE OF CREDIT				1,349,938				63,982	6	
7			X	INSURANCE FINANCING								1,021	7	
8	RELATED PARTY	X										2,190	8	
9	TOTAL Facility Related						\$	6,266,626				\$	438,173	9
	B. Non-Facility Related*													
10	IRS, IDR, ETC		X	LATE FEES									10	
11													11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$		14
15	TOTALS (line 9+line14)						\$	6,266,626				\$	438,173	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

\$

1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$

2

3. Under or (over) accrual (line 2 minus line 1).

\$

3

4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)

\$

105,000

4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

\$

5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

\$

6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$

105,000

7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1997

1998

1999

2000

2001

8

9

10

11

12

FOR OHF USE ONLY

13

14

15

16

FROM R. E. TAX STATEMENT FOR 2001

PLUS APPEAL COST FROM LINE 5

LESS REFUND FROM LINE 6

AMOUNT TO USE FOR RATE CALCULATION

\$

\$

\$

\$

13

14

15

16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GROSSE POINTE MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0045203

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: B. General Construction Type: Exterior BRICK Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES (X) NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME		2001	\$ 573,648	1
2					2
3	TOTALS			\$ 573,648	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2001		\$ 3,862,200	\$ 134,598	27.5	\$ 134,598	\$	\$ 269,196	4
5											5
6											6
7											7
8					25,306	649	35	723	74	6,748	8
	Improvement Type**										
9	ICE MACHINE DRAIN/COOLING PUMP/WATER PUMP			2001	6,224	226	27.5	226		446	9
10	ROOFING			2001	34,800	1,265	27.5	1,265		1,698	10
11	SURVEILLANCE EQUIP/ANTENNA			2001	2,250	82	27.5	82		140	11
12	TELEPHONE/SPLITTERS			2001	609	7	7	7		609	12
13	DINING CAR/ROOM SIGNS			2001	8,744	318	27.5	318		383	13
14	MONITOR / CAMERA			2002	5,303	145	27.5	145		145	14
15	MEZUZAHs			2002	2,240	64	27.5	64		64	15
16	WIRING / WATER VALVE / PUMP / VENTILATOR			2002	7,756	158	27.5	158		158	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,955,432	\$ 137,512		\$ 137,586	\$ 74	\$ 279,587	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 14,456	\$ 4,328	\$ 1,445	\$ (2,883)	10	\$ 2,890	71
72	Current Year Purchases	16,842	2,358	1,684	(674)	10	1,684	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	365,029	118,781	36,297	(82,484)	10	79,361	74
75	TOTALS	\$ 396,327	\$ 125,467	\$ 39,426	\$ (86,041)		\$ 83,935	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RELATED PARTY			\$ 3,212	\$ 906	\$ 1,070	\$ 164		\$ 2,228	76
77										77
78										78
79										79
80	TOTALS			\$ 3,212	\$ 906	\$ 1,070	\$ 164		\$ 2,228	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,928,619	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 263,885	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,082	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (85,803)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 365,750	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy:
- ☐ YES☐ NO
- Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
☐ YES☐ NO
16. Rental Amount for movable equipment: \$7,106Description:SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	CHRYSLER LHS 2000	\$136.00	\$2,963	17
18					18
19					19
20					20
21	TOTAL		\$136.00	\$2,963	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER AIDE

☐
☐
☒

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER AIDE

☐
☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

ALLOCATION OF COSTS (d)

		12		3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 1,800	\$	\$ 1,800
2	Books and Supplies		150		150
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 1,950	\$	\$ 1,950
10	SUM OF line 9, col. 1 and 2 (e)	\$ 1,950			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 18,697	\$		\$ 18,697	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,444			2,444	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			27,944			27,944	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				59,378		59,378	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB, SUPPLIES	39-2					13,522		13,522	13
14	TOTAL			\$		\$ 49,085	\$ 72,900		\$ 121,985	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	689,995		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,227		6
7	Other Prepaid Expenses	3,759		7
8	Accounts Receivable (owners or related parties)	10,000		8
9	Other(specify): DUE FR PRIOR OWNER	40,843		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 758,824	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	67,925		15
16	Equipment, at Historical Cost	31,298		16
17	Accumulated Depreciation (book methods)	(12,456)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (speSEC. DEP.	300		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 87,067	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 845,891	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 460,208	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,349,938		29
30	Accrued Salaries Payable	135,542		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	11,015		31
32	Accrued Real Estate Taxes(Sch.IX-B)	105,000		32
33	Accrued Interest Payable	1,231		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,062,934	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,062,934	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,217,043)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 845,891	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (909,255)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (909,255)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(307,788)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (307,788)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,217,043)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,411,883	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,411,883	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	41,720	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 41,720	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	55	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 55	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT	1,134	28
28a	VENDING COMMISSIONS NET OF COST	262	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,396	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,455,054	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	746,893	31
32	Health Care	1,446,624	32
33	General Administration	729,493	33
	B. Capital Expense		
34	Ownership	663,644	34
	C. Ancillary Expense		
35	Special Cost Centers	121,985	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,762,842	40
41	Income before Income Taxes (line 30 minus line 40)**	(307,788)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (307,788)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	10	13	\$ 371	\$ 28.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,507	11,414	288,929	25.31	3
4	Licensed Practical Nurses	9,945	11,273	246,509	21.87	4
5	Nurse Aides & Orderlies	52,969	56,044	688,530	12.29	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,917	1,182	16,512	13.97	9
10	Activity Assistants	5,040	5,369	72,507	13.50	10
11	Social Service Workers	1,664	1,836	35,227	19.19	11
12	Dietician					12
13	Food Service Supervisor	3,607	3,858	59,971	15.54	13
14	Head Cook	2,198	2,257	27,309	12.10	14
15	Cook Helpers/Assistants	7,828	8,728	68,260	7.82	15
16	Dishwashers	6,633	6,999	53,002	7.57	16
17	Maintenance Workers	3,226	3,513	55,080	15.68	17
18	Housekeepers	7,645	8,070	70,634	8.75	18
19	Laundry	4,289	4,773	43,526	9.12	19
20	Administrator	2,102	2,333	87,683	37.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,457	5,667	87,516	15.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	12	12	99	8.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,049	133,341	\$ 1,901,665 *	\$ 14.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	104	\$ 4,160	1-3	35
36	Medical Director	120	6,000	9-3	36
37	Medical Records Consultant	17	1,108	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	41	1,620	10-3	39
40	Physical Therapy Consultant	32	1,414	10a-3	40
41	Occupational Therapy Consultant	31	1,402	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	38	1,774	11-3	44
45	Social Service Consultant	32	1,418	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	415	\$ 18,896		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses	419	14,292	10-3	51
52	Nurse Aides	47	2,433	10-3	52
53	TOTAL (lines 50 - 52)	466	\$ 16,725		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
SHERRY MAUER	ADMIN	22.3	\$ 87,683	Workers' Compensation Insurance	\$	38,794	IDPH License Fee	\$ 200
				Unemployment Compensation Insurance		32,865	Advertising: Employee Recruitment	665
				FICA Taxes		145,601	Health Care Worker Background Check	80
				Employee Health Insurance		89,538	(Indicate # of checks performed)	
				Employee Meals		16,699	MARKETING/ADV/PROMO	26,338
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	50
				EMPLOYEE BENEFITS - OTHER		545	LICENSES & PERMITS	3,448
							DUES & SUBSCRIPTIONS	89
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 87,683				MGMT CO ALLOCATION	375
(List each licensed administrator separately.)							TRUST/FRANCHISE/CONTRIB/ETC	(50)
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(0
			\$ 0				Non-allowable advertising	
							(26,338)	
							Yellow page advertising	
							(
							0	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	324,042	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 4,857
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
HEALTH DATA SYSTEMS	DATA PROCESSING		\$ 6,408				Out-of-State Travel	\$
KRUPNICK, BOKOR, KAGDA	ACCOUNTING		4,625					
FROST RUTTENBERG	ACCOUNTING		4,000					
LANER, MUCHIN	LEGAL		9,712				In-State Travel	
SACHNOFF & WEAVER	LEGAL		1,401					0
FINKEL MARWICK	LEGAL		3,905					
PERSONNEL PLANNERS	UC CONSULTANT		1,025				Seminar Expense	
DART CHART SYSTEMS	MEDICARE CONSULTANT		28,150					0
ILL COLLECTION SERVICE	COLLECTION		860				RELATED PARTY	147
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 60,086				TOTAL	\$ 147

* Attach copy of IMRF notifications

**See instructions.

(See instructions.)

[illegible]

Facility Name & ID Number GROSSE POINTE MANOR

0045203

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? _____
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,052 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 16,699 Has any meal income been offset against related costs? NA Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	4,160
	REPAIRS & MAINTENANCE	0
		0
		4,160
3	HOUSEKEEPING	
		0
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	1,531
		0
		1,531
5	HEAT & OTHER UTILITIES	
	GAS HEAT	25,025
	ELECTRICITY	50,470
	WATER	20,612
	CABLE TV - LOBBY	0
		0
		96,107
6	MAINTENANCE	
	GROUNDS MAINTENANCE	6,175
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	2,066
	ELEVATOR MAINTENANCE & REPAIR	4,944
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,480
	FIRE SERVICE	0
		0
		0
		0
		16,665
7	OTHER	
	SCAVENGER	9,248
	SECURITY SERVICE	0
		9,248
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	16,725
	LABORATORY & XRAY EXPENSE	
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,108
	PHARMACY CONSULTANT XVIII B 39-2	1,620
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		19,453
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	1,414
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	1,402
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		2,816
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,774
		0
		1,774
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	1,418
		0
		1,418
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	1,950
		1,950

V.COST CENTER EXPENSES

PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	1,053	1,053
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B0	0
18	DIRECTORS FEES		0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C6,408	
	ADMINISTRATIVE CONSULTANTS	XIX C0	
	PROFESSIONAL FEES	XIX C53,678	
		0	60,086
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F26,338	
	EMPLOYEE WANT ADS	XIX F665	
	CONTRIBUTIONS	VI 20 XIX F50	
	DUES & SUBSCRIPTIONS	XIX F289	
	LICENSES & PERMITS	XIX F3,448	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F80	30,870
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		
	EQUIPMENT REPAIR & MAINTENANCE	2,250	
	OUTSIDE CLERICAL SERVICES	30,000	
	PENALTIES / OVERDRAFT CHARGES	VI 185,677	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	22,362	
	MESSENGER SERVICE	0	
		0	60,289

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D145,601	
	UNEMPLOYMENT COMPENSATION	XIX D32,865	
	WORKERS COMPENSATION INSURANC	XIX D38,794	
	HOSPITALIZATION INSURANCE	XIX D89,538	
	EMPLOYEE BENEFITS - OTHER	XIX D545	
	EMPLOYEE PHYSICAL EXAMS	XIX D0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D0	
	PENSION/PROFIT SHARING PLANS	XIX D0	
	CHICAGO HEAD TAX	XIX D0	307,343
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	1,375	1,375
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G0	
	TRAVEL	XIX G0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	284	284
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	71,498	71,498
27	OTHER		
	BAD DEBTS	VI 246,132	
		0	6,132

GRAND TOTAL COLUMN 3 OTHER

700,052

GROSSE POINTE MANOR
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	156,855	PATIENT MEALS	75618
LESS SALES TAX	(1,491)	ADD EMPLOYEE MEALS	9125
	-----		-----
NET FOOD	155,364	TOTAL MEALS/YEAR	84743
TOTAL PATIENT CENSUS	25,206	NET FOOD	155364
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	84743

TOTAL PATIENT MEALS	75618	COST PER MEAL	1.83
		TIME EMPLOYEE MEALS	9125
ADD # EMPLOYEE MEALS/DAY	25		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	16699
	-----		=====
TOTAL EMPLOYEE MEALS	9125		